

MORROW (P. A.)

Notes on Syphilis.—Syphiloma of the Nose of Unusual Form and Evolution. The Diagnostic Value of Syphilitic Cicatrices. Extra-Genital Chancres, Prognostic Significance of. Professional Syphilis.

BY

PRINCE A. MORROW, M. D.,

Surgeon to the City Hospital; Attending Physician
to the New York Hospital, Department of
Skin and Venereal Diseases.

REPRINTED FROM THE
JOURNAL OF CUTANEOUS AND GENITO-URINARY DISEASES
FOR APRIL, 1896.



NOTES ON SYPHILIS.—SYPHILOMA OF THE NOSE OF UNUSUAL
FORM AND EVOLUTION. THE DIAGNOSTIC VALUE OF SYPH-
ILITIC CICATRICES. EXTRA-GENITAL CHANCRES, PROGNOS-
TIC SIGNIFICANCE OF. PROFESSIONAL SYPHILIS.

By PRINCE A. MORROW, M. D.,

Surgeon to the City Hospital; Attending Physician to the New York Hospital, Department
of Skin and Venereal Diseases.

I. SYPHILOMA OF THE NOSE OF UNUSUAL FORM AND EVOLUTION.

THE patient with the lesions portrayed in Fig. 1 presented her-
self at the New York Hospital, May, 1894, with the follow-
ing history: She was twenty-one years old, had been mar-
ried five years. The first child, three years and ten months old,
is healthy; the second died when about a month old; the third preg-
nancy resulted in a miscarriage. After the miscarriage the mother
suffered from sores in the mouth and throat, with a generalized erup-
tion of reddish spots. The scalp was so profusely studded with
sores that she was compelled to cut off the hair. There has been no
marked alopecia of the scalp, but the eyebrows and eyelashes were en-
tirely lost. The eruption disappeared in about three months.

In October, 1893, an eruption of large tumors appeared over va-
rious parts of the body, many of which have undergone involution,
leaving scars. These tumors have continued to appear since. At the
present time there may be seen upon the arms a number of nut-sized
globular tumors springing up from the skin like mushrooms and strik-
ingly suggestive of the tumors of granuloma fungoides. The tumors



are doughy in consistence, but not suppurative. The external aspect of the lower part of the right os humerus is occupied by five or six tumors surrounded by interrupted circles. On the right upper arm are seen tumors which have developed in cicatricial areas which mark

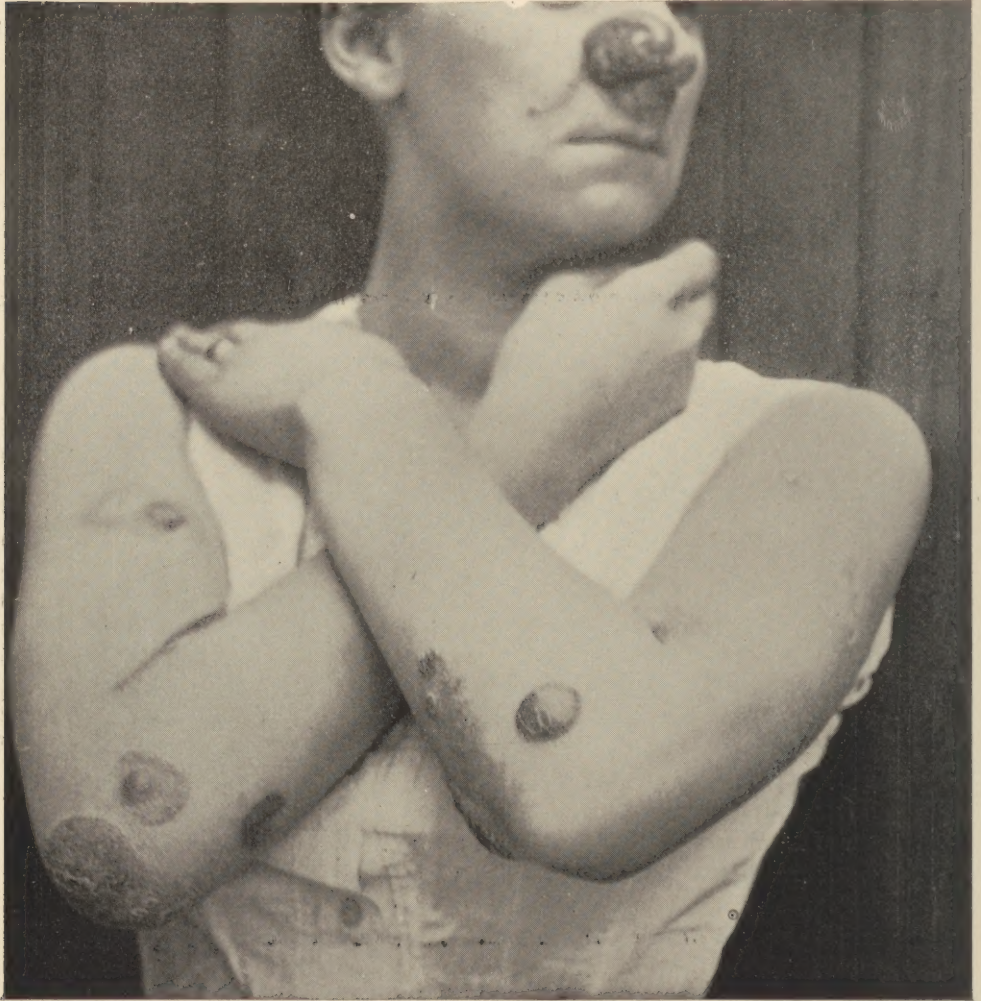


FIG. 1.

the site of former lesions. A cherry-sized gunma occupies the inner border of the left eyebrow. The tumor is soft, painless, and adherent to the skin.

The most interesting feature of this case, however, is the large, tumorlike infiltration which occupies the upper lip, blocking the aperture of the left nostril, and mounting upward on the left ala to the bony and cartilaginous junction. This infiltration does not extend upon the cheek, and is sharply demarcated from the healthy skin. The mass is surmounted and circumscribed above by a large, welt-like ring of infiltration which is exceedingly dense and hard to the feel. The lower part of the tumor is less resistant and softer in consistence. Under the influence of mixed treatment the tumors upon the arms and left eyebrow underwent rapid involution, but the lesion of the nose and lip was scarcely modified, although the constitutional treatment was re-enforced by the application of ung. hydrarg. and mercurial plaster.

So peculiar was this lesion in its form and consistence and so refractory to specific treatment, that a suspicion of its representing a combination of syphilis and tuberculosis was entertained. The patient was presented before the New York Dermatological Society. Some of the members thought that there was probably a tuberculous element present, and suggested the removal of a piece, to be examined for tubercle bacilli. This proposition was not acceptable to the patient, and she ceased her visits. I afterward learned that later she went to the Vanderbilt Clinic, and after some weeks of specific treatment the tumorlike mass on the side of the nose softened, broke down, and disappeared. I examined the patient January 29, 1896, and found that there was some infiltration of the upper lip, which, she states, becomes swollen and enlarged at each menstrual period. The left ala is somewhat contracted, showing at two or three points slight loss of substance.

II. DIAGNOSTIC VALUE OF SYPHILITIC CICATRICES.

Syphilis possesses the peculiarity not only of manifesting itself during its active stage by lesions which are typical and characteristic, but also of leaving indelible traces of its action upon the cutaneous surface in the shape of cicatrices. Another peculiarity of syphilis is its mysterious uncertainty. No matter how mild or malignant its past, there is always the possibility of a formidable future. Long after the fires of the disease have apparently burned out, revealing in the scarred tissues the nature of the destructive process that has swept over them, they may break out anew upon the surface or be rekindled in some important central organ. So profound and permanent are the changes in the tissues wrought by syphilis that the exhumed bones of prehis-

toric sepultures may preserve positive evidences of their syphilitic origin and nature.

While the imprints of syphilis upon the cutaneous surface are not always so typical as to enable even the most practiced observer to decipher the nature of the process which has produced them, yet in many cases they have a positive value as a retrospective aid in diagnosis. It is not intended to assert that the cicatricial remains of syphilitic ulceration present characters which are absolutely distinctive. Syphilitic scars taken singly may be exactly imitated by the scar following a burn, a traumatism, or the ulcerous process of some other disease. But when they are multiple, when they exhibit certain specific peculiarities in their circular or serpiginous outline, their grouping, their pigmentation, their localization, they may be just as characteristic of syphilis as were the lesions in their full stage of activity.

Lupus or cutaneous tuberculosis may produce scars similar to those of syphilis, but they are distinguished by their limitation to certain regions and by their minute characters. The scars of tuberculosis are irregular, uneven, and vicious, with a more livid pigmentation. The cicatrices of varicose ulcers of the leg may imitate closely those of syphilis in this locality, but they are generally limited to the lower third of the leg, while those of syphilis most often occupy the middle and upper third. The pigmentation of the former is more diffuse and permanent, often spreading over one half or more of the limb, while the pigmentation of syphilis almost invariably clears up, leaving white scars. The scars of zoster may be multiple and indistinguishable in their appearance from those of the small tubercular syphiloderm, but they are differentiated by their asymmetry and their localization along the course of certain nerves.

In the picture presented in Fig. 2 we have an example of scars which are typical of syphilis, not only in their minute objective characters, but in their localization and general distribution. They are rounded or circular, more or less depressed, according to the depth of the ulcerative process, the older ones white, with a vanishing zone of pigmentation, the more recent ones red, encircled with a dark-brown, almost black area of pigmentation. These vestiges or marks of an antecedent syphilitic ulceration are typical and will remain so during the lifetime of their bearer. Such stigmata would be of great value in the diagnosis of any obscure nervous or visceral complication in the future.

All specialists are accustomed to have referred to them cases in which it is extremely difficult to differentiate between the late manifestations of syphilis and other diseases. The late surface lesions of

syphilis may in most instances be diagnosticated by their optical characters; the same is true of affections of the mouth, tongue, and throat.

Lesions of the testicle, bones, and joints may also often be distin-



FIG. 2.

guished by objective characters peculiar to syphilis, but in the presence of syphilitic affections of the internal organs, and especially in obscure diseases of the nervous system, the symptoms do not differ essentially from the symptoms of other diseases affecting these organs. Any sign which would lead to the identification of syphilis as the ætiological factor in such cases is of the utmost importance. While recognizing the value of the patient's history in throwing light upon the nature of obscure affections, we find that many syphilitics are unwilling to own up to an avowal which they consider an impeachment of their morals and respectability. They will fence with the examiner, and, in answering questions, conveniently forget any circumstance which might indicate the syphilitic origin of their trouble. Especially is this the case with women. In such cases the discovery of characteristic syphilitic scars may furnish the connecting link between doubtful symptoms and syphilis. Such a discovery is most fortunate for the patient, as, thanks to the wonderful efficacy of specific treatment, it carries with it in many cases an almost certain assurance of cure.

III. EXTRA-GENITAL CHANCRES.

During the past three years twenty cases of extra-genital chancre have occurred in my public practice. Fifteen of these cases came under my observation at the New York Hospital, and five were seen in my service in the City Hospital.

In my private practice within the same period ten physicians have consulted me for chancres of the hand or fingers contracted in the exercise of their professional work. To speak with absolute accuracy, only nine of these were seen by me; the tenth came to consult me last summer, during my absence from the city, and was seen by my assistant, Dr. Johnston, who took notes of the case.

I am well aware that extra-genital chancres are by no means rare in the practice of specialists. My object in reporting these cases is not to illustrate new and interesting clinical features, but simply to utilize them as a basis for certain deductions of practical importance. The clinical appearances and course of extra-genital chancres are so familiar that a detailed description of each individual case is unnecessary. Certain points in relation to their location and ætiology may, however, be of interest. In the twenty cases seen in public practice there were:

Chancres of the upper lip.....	3
" " lower lip.....	5
" " chin.....	3
" " gum.....	1

Chancres of the tongue.....	1
“ “ hard palate.	1
“ “ soft palate.....	1
“ “ pharynx.....	1
“ “ cheek	1
“ “ fingers	2
“ “ anus	1

It will be seen that this series embraces seventeen cephalic chancres, two digital, and one of the anus.

The *chancre of the hard palate* merits especial mention, from the exceeding rarity of the initial lesion in this location. It was deemed of sufficient interest to present the patient before the New York Dermatological Society. In this case the lesion was situated to the left of the median line, and presented the appearance of an ulcerated gumma. The submaxillary glands of the left side were enormously tumefied, obliterating the lines between the jaw and the neck. Any possible doubt as to the nature of the lesion was removed by the appearance of a maculo-papular eruption six weeks after the sore. Concerning the mode of infection no definite information could be gained.

The *chancre of the gum* may also be noted for its comparative rarity. It was situated on the right of the median line, and occupied a surface corresponding to the lateral incisor, the canine, and bicuspid teeth. It presented the appearance of a semilunar erosion of the gum, which was red and slightly tumefied. The epithelium was detached from the center. The chancre did not heal until after the appearance of secondary accidents. In attempting to trace the etiology of the disease, the patient absolutely denied any lascivious contact. He was a barkeeper by occupation, and ascribed the contagion to a rather curious cause. He was accustomed to use his mouth as a receptacle for the coins which he took from customers until he found it convenient to deposit them in the cash drawer, and he thought himself infected by this means.

In another case—*chancre of the tongue*—curiously enough, the contagion was ascribed to paper money. The patient, a young woman twenty-six years old, presented herself at the New York Hospital with a corneous syphilide of the palms and a general papular eruption. She denied most indignantly that she had exposed herself to contagion in the usual way, and her claim of virginity was confirmed by an examination. There was no trace of enlarged glands in the groin. She stated that her occupation as cashier in a large establishment required her to count a great deal of currency every evening. In counting over the rolls of bills she was accustomed to moisten her finger by placing

it on the right side of the tongue. Some three or four months ago she observed that this part of the tongue became quite sore, so that she had to moisten her finger by touching the tip of the tongue. The side of the tongue continued sore, and soon afterward the glands of the right side became enlarged, followed later by patches on the tonsils and an eruption on the cutaneous surface. Examination disclosed on the side of the tongue at the point she indicated a slight cicatricial depression, which in all probability marked the site of the initial lesion.

The most minute examination failed to discover any other probable seat of the chancre.

One of the three cases of *chancre of the chin* was distinguished by its enormous dimensions. It occupied nearly the entire surface of the chin, extending from the edge of the lip to the mental border. The surface was ulcerated, the edges elevated, hard, and everted, presenting the appearance of an ulcerated epithelioma. As a matter of fact, the patient's physician had made this diagnosis, and he had been sent to the New York Hospital to have the "cancer cut out." Before operating, the house surgeon referred the case to me for an opinion. The diag-



FIG. 3.

nosis of epithelioma was contraindicated by the age of the patient, the optical features of the lesion, its rapid development, and the precocious implication of the glands. Any possible doubt as to its specific nature was set at rest by the appearance of a macular eruption on the chest and other signs of constitutional syphilis. Notwithstanding the enormous volume of the lesion, there was scarcely any appreciable cicatrix left after its involution.

One of the cases of *chancre of the upper lip* was also remarkable for its elephantine proportions. The entire upper lip was enormously tumefied, everted, with a fungating, easily bleeding surface. The

inflammatory induration was so marked as to almost completely immobilize the lip. The other lip chancres presented nothing in their appearance or mode of evolution to call for special description. The aetiology was variously referred to kissing, contact with pipes, etc. In one case a chancre of the lower lip in an infant had been contracted from a syphilitic nurse.

The *chancre of the anus* was the result of unnatural practices, to which the patient confessed. The chancre over the *malar portion of the left cheek* was the result of a blow received in a fight with a drunken man. The cases of *chancre of the finger*, both of which were seen in the City Hospital, were ascribed to bites received in drunken brawls. In one of these cases, some months after the chancres had healed, the entire integument of the index finger presented a dusky-red appearance.

In this connection I may present the picture of a chancre over the knuckle of the right hand (Fig. 3) sent to me by the late Dr. E. R. Palmer. It resulted from a blow which the patient administered to a drunken tramp. The skin was broken by the force of the blow. A few weeks afterward the lesion depicted appeared, and was followed by a characteristic eruption.

In the ten cases of professional syphilis the location of the chancres was as follows:

Chancre of terminal phalanx of index finger.....	5
“ “ “ middle finger.....	1
“ “ “ little finger.....	1
“ “ “ thumb.....	1
“ distal extremity of first metacarpal bone.....	1
“ outer border of wrist.....	1

As regards the location of chancres of the hand and fingers, Fournier's statistics, embracing eighty-eight cases, give only one case of chancre of the wrist, while the thumb and the little finger were only very exceptionally its seat. Chancre of the middle finger, according to Fournier, is most often the result of contamination in venereal dalliance.

In none of these eight cases of digital chancre was the lesion hypertrophic or fungating. Two of them were examples of the panaris type, while the others were of the superficial erosive or slightly ulcerous type, with a brownish or dusky-red elevated and indurated base. The accompanying picture (Fig. 4) of chancre of the forefinger in one of these cases was taken after the lesion was in process of healing. All were accompanied with epitrochlear and axillary adenopathy, with

one exception. In this case I could not detect the slightest trace of glandular enlargement. To be clear upon this point, I wrote to the patient recently, who replied: "I have never had an enlarged gland; the only symptoms of syphilis I have had were the first eruption and the throat lesions a year later, which you saw and treated."



FIG. 4.

In regard to the aetiology of these cases, seven ascribed their infection to digital examinations or manipulation in obstetrical or gynaecological work; three, to contamination in the course of surgical work. Two of the latter were infected at the same time in performing a perineal section in a syphilitic patient—the operator through a hangnail on the little finger; his assistant by an accidental prick on the wrist by the knife used in making the section. Some weeks later the operator, alarmed by the long persistence of the sore on his little finger, came to consult me as to its nature. In the absence of any glandular enlargement, I gave a tentative diagnosis of syphilis, which was confirmed ten days later by the appearance of a characteristic eruption. Some two

weeks afterward the surgeon who had assisted at the operation came to consult me. The chancre on the wrist had practically healed, but there was a generalized papular eruption.

As before intimated, these cases are presented not so much for their intrinsic interest as a basis for some general reflections.

The Prognostic Significance of Extra-genital Chancres. As is well known, there is a tradition or belief in the profession that extra-genital chancres are not only more apt to be severe in their local processes, but more liable to be followed by a grave syphilis. Chancres of the fingers, especially, are thought to portend a bad type of syphilis. As the French phrase it, "It is a misfortune for a man to catch the pox; it is a much greater misfortune for him to take it in any other way than by the genital way." This conception that the gravity of a constitutional infection may be modified by the seat of inoculation receives support, it is claimed, from analogy with other infectious diseases. Thus, for example, there has been observed a marked difference in the relative mortality of mad-dog bites according to the region in which the virus is implanted. The mortality of rabies is four times greater from wounds of the face and neck than from wounds of the lower extremities. This difference may, however, be explained partly on the ground that as the lower members are habitually clothed, the virus is often absorbed by the clothing, while the richer lymphatic and vascular supply of the face furnishes more favorable conditions for successful inoculation. In the case of syphilis, however, it is difficult to believe that the constitutional effects of the syphilitic virus are materially modified by its port of entry into the system. So far as the *local effects* are concerned, we can readily understand why their severity may be influenced by the accident of location.

Chancres of the fingers, especially those of the panaris type, are proverbially painful and apt to be attended with severe glandular complications. The pain is readily explicable from the character of the tissues involved, the structures being compact, dense, and resisting, and the nail bed endowed with the most exquisite sensibility. Sympathetic irritation, no doubt, enters as a factor in the production of adenitis. Again, the digital chancre is subject to numberless causes of irritation from pressure, painful contacts, and knocks, etc., besides being exposed to secondary infection from pyogenic germs; the septic process thus set up is not infrequently attended with severe lymphangitis, pyæmia, and other complications.

Likewise, chancres of the lips, tongue, and pharynx are exposed to multitudinous causes of irritation from contact with food, spices, hot liquids, etc., while the constant movement of the parts in talking and

swallowing interferes with the rest necessary to prompt healing. Chancres of the tonsil especially have a bad reputation. The structure of the tonsil is favorable to syphilitic infiltration, while its crypts and anfractuositities constitute favorable breeding places for pyogenic cocci. The malaise, fever, and other signs of constitutional disturbance are doubtless due, in many cases, to secondary infection. Some time ago I had a case of chancre of the tonsil in private practice which had been previously treated for four weeks as a case of diphtheria under the care of two physicians and a trained nurse. The identical aspect of the false membrane of chancre of the tonsil with that of diphtheria would extenuate but not excuse the mistake in diagnosis.

As regards the local process, it may be conceded that extra-genital chancres are more apt to be severe, but this increased severity is due to peculiarities of anatomical structure of the parts and local causes of irritation. But, advancing a step further, do we find that the accident of location influences the ulterior evolution of the disease—in other words, is syphilis contracted extra-genitally more grave in type than syphilis received in the ordinary way?

So far as my observation of these cases would throw any light upon the determination of this question, it must be answered in the negative. In none of them was the gravity of the resulting syphilis more pronounced than in the average run of patients. Of the dispensary cases the majority have been under my observation for variable periods—some of them constantly for more than two years. Most of them have attended with the intermittent regularity which characterizes patients of the dispensary class; they would continue to come until the disappearance of existing accidents, and then cease their visits until the recurrence of another outbreak of symptoms.

Of the ten physicians who figure in the above category, four still continue under my personal care; two of them, who live at a distance, I hear of from time to time; the remaining four passed from my observation as soon as the diagnosis was definitely established. Notwithstanding the fact that physicians are notoriously bad patients, in all these six cases the constitutional symptoms have thus far been of mild or medium severity.

It is evident, however, that conclusions based upon the observation of syphilis during the secondary stage have a comparative rather than an absolute value, because, except in malignant precocious syphilis, the elements of gravity are only manifest at a later stage.

This question has been studied by Prof. Fournier in his usual careful and scientific manner. In a recent lecture upon the "Comparative Gravity of Extra-genital and Genital Chancres," he has analyzed a

large number of personal statistics, covering long periods, which directly bear upon the determination of this question. Starting with the general proposition that statistics of ten thousand cases of chancre show that ninety-three per cent are genital and seven per cent are extra-genital, he has considered the criteria upon which the gravity of syphilis may be based.

1. *The occurrence of tertiary accidents* he regards as one of the best criteria of the gravity of syphilis. In twelve hundred cases of tertiary syphilis he found that in six or seven per cent it originated in extra-genital chancres, and in ninety-three to ninety-four per cent it had for its point of departure genital chancres. The second criterion is *the occurrence of*

2. *Malignant precocious syphilis*. In two hundred and forty-two cases of malignant precocious syphilis genital chancres were responsible for ninety-two per cent, and extra-genital chancres for seven per cent of the cases.

3. *The occurrence of cerebral syphilis*, which is accepted as the most formidable accident of syphilis, he takes as the third criterion of gravity. In seven hundred and seven cases of cerebral syphilis ninety-five per cent made their *début* by genital chancres, and only five per cent resulted from extra-genital chancres. These statistics, which were taken impartially without knowing where they would lead, would seem to prove that so far as cerebral syphilis is concerned it would more likely result from a genital than an extra-genital chancre.

Notwithstanding these statistics, Fournier still insists that the digital chancre is grave, not because of its location but because of the soil in which it generally develops. It occurs, as a rule, upon the physician who is generally run down and fatigued. The moral effect is, moreover, depressing, since the physician, knowing the dangers of the disease, lives in a state of great anxiety. Finally, physicians do not take care of themselves. Some have a therapeutic skepticism, some treat themselves, while others consult a great number of their *confrères*, and continually change their medication.

Upon this point the opinion of another distinguished authority may be quoted. Mauriac, in his recent work (1895) on the Treatment of Syphilis, says: "Chancres of the fingers have a bad reputation, and it is merited. In the first place, they are often grave in themselves, especially when they are large, ulcerated, and fungous, and when they become complicated with an inflammatory panaris, with pain, necrosis, etc. But they are especially dangerous and almost impressed with malignity in their consequences as to general infection.

All authorities are united upon this point. It is incontestable that syphilis from a digital chancre is a dangerous syphilis, and turns easily to tertiarism. This fact is difficult to explain."

PROFESSIONAL SYPHILIS.

Without further discussing this aspect of the question, it may be said that chancres of the fingers possess a peculiar interest for physicians, who from their occupation are most exposed to contract syphilis through this medium. While medical men can not claim an exclusive monopoly of digital chancres, yet they are immeasurably more common among accoucheurs and surgeons. In Fournier's statistics of forty-nine cases, thirty occurred in physicians. These facts emphasize the following points:

1. *The Personal Risks of the Physician.*—Medical men, especially those engaged in obstetrical and surgical work, can not be too strongly impressed with a recognition of the risks incurred. Professional syphilis is much more common than is generally supposed, and for obvious reasons. Syphilis is not a disease which reflects credit upon its possessor, and the unfortunate victim is not eager to proclaim himself a syphilitic. On the contrary, he is disposed to carefully conceal the nature of his disease, not only from motives of delicacy, but because of the injury to his professional interests which a knowledge of the fact would carry with it. In years past I have seen a great number of cases of professional syphilis, and know of at least two recent cases among my colleagues of the City Hospital which have not been included in the above category. Forewarned is forearmed, and the recognition of the danger would lead to greater care in the protection of the fingers, and greater circumspection, not only in the examination of known syphilitics, but of patients of whose history and antecedents nothing is known. It is a noteworthy fact that specialists in venereal diseases who are most exposed to constant contact with syphilis are rarely contaminated. This is because they recognize the danger and take greater precautions to guard against infection.

2. *The Risk to Others.*—The important fact must not be lost sight of that the dangers of professional syphilis are not purely personal; they are not to be measured alone by the risks of contagion to the patient's family and intimates. A digital chancre involves serious danger to those with whom its bearer comes into professional relations. The many well-attested local epidemics of syphilis which have originated from a chancre on the finger of an accoucheur, besides numerous scattered cases where one or more women, and through them their families, have been contaminated in the same way, furnish a large

contingent of cases in the literature of syphilis insontium. I might refer to the historical epidemic of St. Euphémie, originating from a chancre on the finger of a midwife, where fifty women were the immediate victims; to the epidemic of Brives (1874), reported by Bardinet, when thirty-one cases of syphilis, with four deaths, were traced to a midwifery chancre, etc. Enough has been said to show that a chancre on the hand of any one engaged in obstetrical work may be a prolific cause of syphilitic infection.

These facts suggest an ethical question of great practical importance, viz., whether a physician is justified in continuing his professional work while he bears upon his hands such an active source of contagion. The surgeon, or the physician in general practice, may be able to render himself innocuous to his patients by a suitable protective dressing—such as a rubber stall, for example. Where the chancre is inflamed and very painful, the pressure of such an appliance would render its use impossible. So far as the accoucheur is concerned, there can be no doubt as to his manifest obligation to discontinue his work until the chancre is healed. The fact that he can ill afford to give up his work during this long period does not affect the moral aspect of the question. One of the physicians who came to consult me had a very large obstetrical practice in this city, and he had continued to attend to his work for several weeks after the chancre appeared. To my question as to how many women he had exposed to possible contagion during this period he was unwilling to reply. He assured me, however, that not even a suspicion of the syphilitic nature of the sore had crossed his mind until the eruption appeared. This brings us to the consideration of

3. *The Importance of an Early Diagnosis of the Digital Chancre.*
—I have been more than once surprised at the invincible repugnance on the part of the bearer of such a lesion to recognize its true nature. Almost all of them maintain that it must be a simple sore, a felon, a septic infection, or something else, and they cherish this delusion until their perceptions are quickened by the appearance of unmistakable constitutional symptoms. One of my patients, acting on the advice of his *confrères*, that his chancre was an infected wound, had it scraped and cauterized, and the entire chain of glands, including the axillary, extirpated. This procedure delayed somewhat, but did not prevent, the evolution of the disease. A more general recognition of the frequency of this mode of infection on the part of the profession would more readily awaken suspicion as to the possible syphilitic character of any suspicious sore which develops on the fingers. In fact, it would be a safe rule for any physician bearing upon his hand or fingers an

indolent ulcer, which in its appearance and sluggish evolution does not correspond to ordinary lesions in this locality, to at once suspect its possible syphilitic nature.

4. The *prophylactic precepts* which the study of these facts impose are to preserve intact, as far as possible, the integrity of the epidermis of the hands and fingers, and to use great circumspection in making vaginal examinations, and in operations on syphilitic subjects. Observation shows that digital chancres are most often contracted from mucous patches of the vulva, or from masked or concealed lesions in persons not known to be syphilitic. Many physicians, called to a woman in labor, are accustomed to make a digital examination without inspection of the genital parts, or without any knowledge of the condition of the patient's health.

So far as we know, a sound and unbroken epidermis affords a perfect safeguard against inoculation. Cuts, pricks, abrasions, fissures, hangnails, eczematous eruptions—any break of the epidermis from whatever cause—may be a port of entry for the syphilitic virus. Lesions of continuity may be so microscopic as to escape ocular detection, but exposure of the hands to the vapor of ammonia may reveal the existence of unsuspected breaks in the epidermis. It is hardly necessary to insist that the hands should be thoroughly washed immediately after examination of any syphilitic, whether they come in contact with syphilitic lesions or not. For this purpose the free use of soap and hot water is better than the strong mercurial or carbolic washes employed by many surgeons. As a matter of fact, the latter often cause a chapped condition of the skin, thus affording a favorable surface for inoculation. Moreover, the free use of sublimate or other aseptic washes immediately after contact with the secretions or blood of a syphilitic is deceptive as a prophylactic against inoculation. Jullien reports the case of a medical man who was called upon to examine a sore on the glans penis of a patient. He carefully lifted up the organ between the thumb and index finger, but in doing so his middle finger, upon which there was an abrasion, accidentally came in contact with a mucous patch of the scrotum which had not been observed. The contact was but momentary and the part was immediately washed in a strong antiseptic solution; nevertheless, a chancre developed on the finger, followed by severe constitutional infection.
